COMPONENTS OF A FAMILY PLANNING VISIT

I. INTRODUCTION

Delegate agencies must ensure that medical care services are provided under the supervision of a site medical director who is a licensed and qualified physician with training and experience in family planning.

If coloposcopy and related services (cryotherapy, excisional, biopsy) are provided on site, the Maryland Family Planning and Reproductive Health Program requirements for colposcopy services and quality assurance must be met (See Colposcopy Services and Quality Assurance Guideline).

Care should be taken to not put unnecessary barriers to the initiation of effective contraception. A comprehensive physical exam and laboratory work may not be necessary, and the visit should be tailored to the client taking into account the reason for her visit, age, history and the presence of any signs or symptoms warranting further evaluation.

There is no medical or safety benefit to requiring routine pelvic examination or cervical cytology before initiating hormonal contraception. The prospect of such an examination may deter a woman, especially an adolescent, from having a clinical visit that could facilitate her use of a more effective contraceptive method than those available over the counter

Another common practice is requiring one medical appointment to discuss initiation of a LARC method and a second for placement of the device or requiring two visits to perform and obtain results from sexually transmitted infection testing. Clinicians are encouraged to initiate and place LARC in a single visit as long as pregnancy may be reasonably excluded. Sexually transmitted infection testing can occur on the same day as LARC placement, and women do not require cervical preparation for insertion

The frequency and extent of investigation of the individual components are dependent on the type and frequency of each family planning visit, reason(s) for the visit, contraceptives in use and/or being considered for use and findings from the physical examination and laboratory testing. Similarly, revisits should be individualized based on the patient needs and the reason for the visit.

II. HISTORY

The initial comprehensive visit must include a complete medical history. Pertinent components of this history must be updated at subsequent clinical visits.

A. General History
   1. Reason for visit
   2. Age
   3. Allergies- Drug, latex, food and seasonal
   4. Current medications/vitamins/herbs
   5. Gender orientation

6. Gender preference
7. Current method(s) of contraception
8. Previous method(s) of contraception
9. Current primary care clinician

B. Sexual History
   1. Age of onset
   2. Number of partners
      a. Current
      b. Since last visit
      c. Lifetime
   3. Partner infection history/partner high risk behavior
   4. Gender of partners
   5. Types of sex acts (e.g. penetrative or not, vaginal, anal, oral)
   6. High-risk behavior (e.g. multiple partners, MSM, unprotected sex, sex with partners who are IVDU or known HIV+ or have history of STI)
   7. Date of last vaginal intercourse

C. Obstetric History
   1. Gravidity
   2. Parity
      a. Term births
      b. Preterm birth
      c. Abortions (spontaneous or elective)
      d. Living children
   3. History of ectopic
   4. Delivery type(s)
   5. Complications
   6. Date of last delivery / date of last pregnancy termination
   7. Breastfeeding

D. Gynecologic History
   1. Last menstrual period
   2. Menarche
   3. Length of cycle
   4. Length of flow
   5. Pap/colposcopy/LEEP history

E. Current or Past Medical History
   1. Asthma
   2. Cardiovascular disease
   3. Liver disease
   4. Kidney disease
   5. GI disease
   6. Headaches
   7. Diabetes mellitus
   8. Thromboembolic disease
   9. Coagulopathies
   10. Cancer: ovary, breast, uterus, cervix
   11. Mental health disorders
   12. Other medical problems

F. Surgical History or Planned Surgical Interventions
   1. Gynecologic/ obstetric (e.g. hysterectomy, tubal ligation, myomectomy, cesarean)

2. Breast (e.g. biopsy, reduction, augmentation, lumpectomy, mastectomy)
3. Other

G. Infectious Disease History/Immunization History
1. Reproductive tract infection history (e.g. HPV, HSV, gonorrhea, chlamydia, syphilis, bacterial vaginosis, trichomoniasis)
2. Hepatitis B and C
3. HIV
4. Tuberculosis
5. Other infections
6. Immunization history, including immunization against HPV

H. Social History
1. Alcohol
2. Smoking
3. Drug use
4. Domestic/intimate partner violence or coercion
5. Sexual abuse/assault
6. Child abuse

I. Family History
1. Heart disease
2. Diabetes
3. Addictions
4. Cancer (ovary, breast, uterus)
5. Other

III. REVIEW OF SYSTEMS
A. General
B. Vision
C. Head and Neck (H&N)
D. Pulmonary
E. Cardiovascular (C/V)
F. Gastrointestinal
G. Genito-Urinary
1. Hematuria
2. Dysuria
3. Nocturia
4. Incontinence
5. Urgency
6. Frequency
7. Incomplete emptying

H. Ob/Gyn/Breast
1. Amenorrhea
2. Unscheduled/irregular bleeding
3. Postmenopausal bleeding
4. Vaginal discharge
5. Vaginal pain, pruritus, irritation
6. Pelvic pain
7. Lesions
8. Breast or nipple pain
9. Breast or nipple masses
10. Nipple discharge

11. Breast or nipple rashes/skin changes

I. Neurological
J. Musculoskeletal
K. Mental Health/Depression Screen
L. Skin and Hair

III. PHYSICAL EXAMINATION

The components of the physical examination should be determined by the reason for the visit as well as by the client's age, history and any presenting signs and symptoms unveiled by the ROS. There is no medical or safety benefit to requiring routine pelvic examination or cervical cytology before initiating hormonal contraception.

A. Every visit should include a basic physical examination to include at least the following:
   1. Blood pressure
   2. Weight
   3. Height
   4. BMI
B. More detailed exam may be needed bases on reason for visit, history, or signs or symptoms and may include:
   A. Temperature
   B. Thyroid
   C. Heart
   D. Lungs
   E. Breasts
   F. Abdomen
   G. Extremities
   H. Pelvis
   I. Rectum (if indicated by age or risk)
   J. Skin

IV. COUNSELING

All clients should receive counseling on: STI/HIV transmission prevention (and should be offered screening); the importance of routine health maintenance screening procedures (and should be offered screening); methods to avoid unintended pregnancy; and on the importance of preconception care.

A. The initial comprehensive visit must include counseling on the following:
   1. Creation and/or review of Reproductive Life Plan (please refer to *Reproductive Life Plan* guideline)
   2. Importance of routine exams for preventative health maintenance:
      a. Blood pressure evaluation
      b. Breast exam
      c. Pelvic exam
      d. Pap smear
      e. Colo-rectal screening (in individuals > 40)
      f. STI screening including HIV
   3. Preventing unintended pregnancy

a. Abstinence/postponing sexual involvement
b. Contraceptive options
c. Emergency contraception

4. Reinforce importance of preconception care and counseling if planning pregnancy (see Reproduce Life Plan)
5. Sexually transmitted infections/ HIV transmission
    a. Partner selection
    b. Barrier protection

B. The following items should be included as indicated by history and physical exam:
1. Weight/Diet/Nutrition
2. Vitamins and Minerals
    a. Iron
    b. Folic acid
    c. Calcium
3. Exercise
4. Psychosocial
    a. Personal goals
    b. Behavior/learning disorder
    c. Abuse/neglect
    d. Interpersonal/Peer/Family relationships
    e. Family involvement
    f. Domestic violence
    g. Depression/Suicide
    h. Lifestyle/Stress
5. Health/Risk behaviors
    a. Substance abuse (drugs, tobacco, alcohol, prescription medications)
    b. Excess ultraviolet light
    c. Tattoos/Body piercing

V. LABORATORY TESTING

Laboratory tests should be provided as required by results of history, physical examination, and counseling components of visit. Specific laboratory testing may also be required for the provision of specific methods of contraception (refer to specific method guidelines).

The following laboratory tests must be available:

A. Hgb/Hct
B. Rubella screen
C. Hepatitis B screen
D. HIV
E. Wet mount/Vaginitis screen
F. VDRL or RPR
G. Urine dipstick
H. Pap
I. GC
J. Chlamydia
K. HPV
L. Urine pregnancy test (on site)

REFERENCES

1. ACOG. Committee Opinion. Access to Contraception. 2015.

2. ACOG. Guidelines for Women's Health Care: A Resource Manual, 4th Edition. 2014.

3. Hatcher RA et al. Contraceptive Technology. 20th Revised Edition. Ardent Media, Inc., New York, 2011.